testing/delivering and definition of the CL test threshold. The values obtained were Lr discriminate between true-positive and true-negative patients. For the whole-hyperbolic cohort, the total costs of the FN and CL were 2.3 billion and 890 million, respectively. The difference of avoided hospitalizations between the tests was 244 for FN. ICER was BRL 5,834.35. CONCLUSIONS: Both diagnostic tests are important alternatives for the decision makers accounting for intervention effects that fall outside the conventional

The effectiveness of oxyprogesteronicaproas therapy was 88.6%, and dydrogesterone - 93.6%, the cost of treatment was BRL 78.63 and BRL 86.52 respectively. Cost-effectiveness ratio was BRL 88.7 for oxyprogesteronicaproas and BRL 89.9 for dydrogesterone.

PH26
COST-EFFECTIVENESS OF INFANT PNEUMOCOCCAL VACCINATION IN THE NETHERLANDS

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OBJECTIVES: The Dutch National Immunization Program offers the 10-valent pneumococcal conjugate vaccine (PCV10). Also licensed for use in the infant population is the 13-valent PCV (PCV13). To update cost-effectiveness (CE) estimates of PCV13 over the long run, current and economic models were used to modelled vaccinating a birth cohort with either PCV10 or PCV13 (3+1 dose schedule), and calculated costs and effects linked to resulting disease. We modeled invasive pneumococcal disease (IPD), non-invasive pneumonia and acute otitis media, and considered death and lifetime impairments following IPD. We calculated direct costs in the vaccinated cohort and indirect effects - herd immunity for the vaccine-type (VT) serotypes and replacement for the non-VT serotypes - in the rest of the population.

Since no price is available, we use a price difference of BRL 11 per dose and vary this price difference in sensitivity analyses. Epidemiological and economic data are taken as current as possible. A set of scenarios explore different assumptions, including different sets of epidemiological data, assumptions on vaccine efficacy and indirect effects on cost (IC) for all disease associated with H2 and to a larger extent, PHN. In addition, studies found that vaccine efficacy against PHN age at vaccination, and vaccine cost strongly influenced the results in sensitivity analysis.

Methods: We searched MEDLINE and EMBASE databases for eligible studies until June 2013. We extracted information regarding model structure, model input parameters, and study results. We compared the results across studies by projecting the health and economic impacts of vaccinating 1 million adults over their lifetimes. We included 14 cost-effectiveness studies performed in North America and Europe.

Results: A total of BRL 856.77 for dienogest and BRL 859.0 for dydrogesterone respectively. Taking only direct costs into account PCV13 cannot be considered cost-effective, unless the price difference is much lower than BRL 11 per dose. In three scenarios, PCV10 dominates PCV13, in the other scenarios the ICER is between BRL 800000 and BRL 1500000 per QALY gained. In indirect effects we also take into account the ICER of PCV13 compared to PCV10 is below BRL 20000 per QALY for all scenarios. Scenarios do not have a large impact on the policy decision, unless we assume extra efficacy of PCV10 against non-typeable Haemophilus influenzae.

Conclusions: Replacing PCV10 with PCV13 is not likely to be cost-effective in preventing pneumococcal disease in young children. Taking potential benefits in elderly into account, PCV13 is likely cost-effective. The CE of PCV13 was highly sensitive for indirect effects our analysis.